No. 98-1536

(5)

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In The

SUPREME COURT OF THE UNITED STATES

October Term 1998

Randon Bragdon, D.M.D.,

Petitioner,

v.

Sidney Abbott, et al.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

PETITIONER'S SUPPLEMENTAL BRIEF

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PETITIONER'S SUPPLEMENTAL BRIEF

Petitioner Randon Bragdon, D.M.D., has petitioned for review of, inter alia, what level of risk is legally significant under the direct threat provisions of the Americans with Disabilities Act ("ADA"), and whether health care workers are required by the ADA to confront greater risks than patients or other citizens. On page 21, note 5, and page 28, of his petition, Dr. Bragdon cites *Onishea v. Hopper*, 126 F.3d 1323 (11th Cir. 1997), *vacated for en banc review*, 133 F.3d 1377 (11th Cir. 1998). On April 7, 1999, the Eleventh Circuit issued its en banc decision in *Onishea v. Hopper*, ___ F.3d ___ , 1999 WL 190763 (11th Cir.). The en banc *Onishea* decision is significant for Dr. Bragdon's petition for several reasons.

I. *ONISHEA* FURTHER ILLUSTRATES A CONFLICT AMONG THE CIRCUITS ON WHAT LEVEL OF RISK IS LEGALLY SIGNIFICANT UNDER THE ADA.

The ADA defines a direct threat as a significant risk to the health or safety of others that cannot be eliminated by reasonable modifications of policies, practices, or procedures, or by the provision of auxiliary aids or services. 42 U.S.C. § 12182(b)(3); 28 C.F.R. § 36.208(c). *Onishea* further illustrates a conflict among the circuits on what constitutes a direct threat under this significant risk standard.[1] As *Onishea* explains, *see Onishea*, 1999 WL 190763, *6-*7, the Fourth, Fifth, Sixth, and now the Eleventh Circuits, follow a cautious rule on how low the odds may be, and how much evidence it takes to prove a significant risk, when the adverse event is contraction of a fatal disease or death generally. On the other hand, the First Circuit and arguably the Ninth Circuit take a

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[1] Like other courts, *Onishea* recognizes the direct threat standard is the same under both the Rehabilitation Act of 1973 and the ADA. *Onishea*, 1999 WL 190763, *6 n.14; *see also* Pet. App. 20a-21a (tracing origin of direct threat standard to *Arline*, 480 U.S. 273 (1987)).

substantially less cautious approach. *Compare Montalvo v. Radcliffe*, 167 F.3d 873 (4th Cir. 1999); *Doe v. University of Md. Med. Sys. Corp.*, 50 F.3d 1261 (4th Cir. 1994); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820 (5th Cir. 1990); *Bradley v. University of Tex. M.D. Anderson Ctr.*, 3 F.3d 922 (5th Cir. 1993), *cert. denied*, 114 S. Ct. 1071 (1994); *Estate of Mauro v. Borgess Med. Ctr.*, 137 F.3d 398 (6th Cir. 1998), *cert. denied*, 119 S. Ct. 51 (1998) *with Abbott v. Bragdon*, 163 F.3d 87 (1st Cir. 1998) *and Chaulk v. United States Dist. Ct.*, 840 F.2d 701 (9th Cir. 1988). District Courts in the Third and Eighth Circuits have also followed the more cautious approach. *See Scoles v. Mercy Health Corp. of S.E. Pa.*, 887 F. Supp. 765 (E.D. Pa. 1994); *Doe v. Washington Univ.*, 780 F. Supp. 628 (E.D. Mo. 1991).

II. DR. BRAGDON CLEARLY RAISES A GENUINE ISSUE FOR TRIAL UNDER *ONISHEA'S* DIRECT THREAT STANDARD.

Onishea is one more example of a court applying a direct threat standard under which Dr. Bragdon would clearly deserve a trial, if that standard were applied to him. The Eleventh Circuit reasoned and held as follows:

> . . . [S]ignificance by itself connotes more than size: "significant" means "deserving to be considered," "important," "weighty," or "notable." And it is the potential gravity of the harm that imbues certain odds of an event with significance. . . .
>
> Thus, when the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low: death itself makes the risk "significant."
>
> . . . .
>
> . . . . Accepting proof of a theoretically possible method of transmission as sufficient

> recognizes—unlike the First Circuit's approach—that saying a risk of an event is small does not mean that it will not happen. And each time the event occurs, it is real people—not cold ciphers—that suffer the consequences. Saying that only one in 42,000 persons will die if exposed to a risk, *see Mauro*, 137 F.3d at 407, does not make that one's death insignificant.
>
> We thus hold that when transmitting a disease inevitably entails death, the evidence supports a finding of "significant risk" if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease. This is not an "any risk" standard: the asserted medical danger of transfer must be rooted in sound medical opinion and not be speculative or fanciful. But this is not a "somebody has to die first" standard, either; evidence of actual transmission of the fatal disease in the relevant context is not necessary to a finding of significant risk.

Onishea, 1999 WL 190763, *6-*8.

Dr. Bragdon's evidence clearly satisfies this standard. For example, CDC's seven reported cases of possible occupational HIV transmission to dental workers by themselves establish both that the event can occur, namely, percutaneous occupational exposure of dental workers to HIV-infected blood, and that the event can transmit the disease. *See* Petition pp. 14-16 and Pet. App. 224a, 549a-550a. The affidavit testimony of Dr. Sanford Kuvin, M.S., M.D., D.T.M. & H., also by itself establishes the event can occur and the event can transmit the disease. *See* Pet. App. 606a (1 in 66,667 risk per intra-oral injection); *see also* Pet. App. 573a-575a, 602a-610a.

From a qualitative standpoint, in 1993, Centers for Disease Control and Prevention ("CDC") characterized the HIV risk from dentists to patients as "small," Pet. App.

530a, and experts on both sides in this case agree the risk to Dr. Bragdon is at least as great and perhaps "much greater" than the risk to patients, Pet. App. 87a, 191a, 246a, 570a, 581a. Under the qualitative standard for significant risk set by the Eleventh Circuit, such a small-to-much-greater-than-small risk to dentists would be significant.

Similarly, in 1988, and again in 1997, professional articles written for dentists characterized their occupational HIV risk as "low." *See* Carol Chenoweth, et al., *Postexposure Chemophrophylaxis for Occupational Exposure to HIV in the Dental Office*, 128 J. Am. Dental Assoc. 1135, 1136 (Aug. 1997); Klein, et al., *Low Occupational Risk of [HIV] Infection Among Dental Professionals*, 318 New England J. of Med. 86 (Jan. 1988). This professionally recognized level of occupational HIV risk to dentists also meets the Eleventh Circuit's qualitative standard for significance when the adverse event is contracting HIV.

And again, in 1987, CDC warned dentists that universal precautions should be the "minimum precautions" for all dental procedures in which the potential for bleeding exists, thereby recognizing an HIV risk "deserving to be considered" and "notable" despite taking universal precautions. *See* Pet. App. 459a. Under the Eleventh Circuit's standard, this qualitatively "notable" and "deserving to be considered" HIV risk to dentists is also significant, or at least generates an issue for trial in light of Ms. Abbott's private, expert affidavits that the risk is "infinitesimal."[2]

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[2] To Dr. Bragdon's knowledge, no CDC official has ever said the risk to dental workers is "infinitesimal." This includes the affidavits from Dr. Wayne Marianos in this case, which, in any event, the Court agreed may not be used against Dr. Bragdon, *see* Pet. App. 22a. Only Ms. Abbott's private, **non**-public health official experts, Dr. Molinari and Dr. Craven, have offered affidavit opinions that the risk is

It is also noteworthy that, today, CDC takes the position that the risk of HIV transmission to a dental worker who sustains even a "superficial scratch" from an HIV-contaminated instrument is so great he or she should immediately begin four weeks of painful chemo-prophylaxis to reduce his risk of contracting HIV by some unknown factor. *See* Pet. App. 192a-193a, 195a-197a, 201a-204a (four week "basic regimen," as defined at Pet. App. 214a, is recommended for an "EC Code 2" (which includes superficial scratches) from an "HIV SC 1" (asymptomatic HIV-infected patient)), 208a-209. In light of this present day CDC concern for superficial scratches, the view there is no genuine issue for trial that Dr. Bragdon reasonably believed there was a significant risk is incomprehensible.

III. CONTRASTS BETWEEN THE PROCESS AND RESULTS IN *ONISHEA* AND *BRAGDON* ARE A STRIKING REMINDER OF WHY THIS COURT SHOULD EXERCISE ITS SUPERVISORY POWERS IN THIS CASE.

A. Prison Inmates Are Entitled to the Benefit of a Trial and Extensive Findings of Fact, But Dental Workers Are Not.

The HIV-infected prisoners who brought suit in *Onishea* went to trial. At trial, they had the opportunity to present live, thorough, testimony from their experts and other witnesses, and to cross-examine the defendants' experts and other witnesses in front of the fact finder. The

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"infinitesimal." To Dr. Bragdon's knowledge, no professional article or similar source of information published for dentists, before or after 1994, ever characterized the HIV risk to dental workers as "infinitesimal." Published sources assess the risk as "small," "low," or "very small." *See* Pet. App. 569a (reporting in 1993 that an American Dental Association study suggested "that dentists are at small risk of occupationally acquired HIV infection"); Chenoweth, *supra*, 128 J. Am. Dental Assoc. at 1136 (characterizing the risk as "low").

prison inmates had an opportunity to present their case, though not even as fully as the Eleventh Circuit majority thought proper, holding as it did that some of the plaintiffs' evidence was wrongly excluded at trial. Based on the live presentation of evidence at trial, the district court made extensive findings of fact contained in a "476-page opinion [sic]," *Onishea*, 1999 WL 190763 at *4, *8 n.16.

In contrast, Dr. Bragdon has had no trial and there have been no findings of fact. Later, on appeal, the First Circuit somehow expected Dr. Bragdon's attorney to explain in oral argument in less than a few minutes what it would take a medical expert several hours to explain under the best of circumstances. Thereupon summary judgment was affirmed against Dr. Bragdon in a conclusory, three-page appellate opinion. Though technically incorrect, impartial observers uneducated in the law might conclude from the disparity in process between *Onishea* and *Bragdon* that prison inmates simply have greater procedural rights than dental workers, and that prison life is worthy of extremely careful factual consideration, whereas the concerns of dental workers are not.

B. The Lives of Prison Inmates in Alabama are More Valuable Than the Lives of Dental Workers in Maine.

The Eleventh Circuit clearly takes a more cautious approach than the First Circuit on the issue of HIV transmission. For example, by upholding the district court's findings, the Eleventh Circuit, in effect, affirms the view that the risk of HIV transmission from an HIV-infected prison inmate, to non-infected inmates in "clerical classes, . . . floral design classes, . . . nutrition classes, concerts and talent shows," would be significant and could not be rendered insignificant by reasonable accommodations. *Onishea*, 1999 WL 190763, *1. In other words, in Alabama, because of the HIV-risk to uninfected prisoners from HIV-infected students in a floral design class, those with HIV may be excluded under federal law. In contrast,

in Maine, federal law requires dental workers in non-emergency situations to take mortal risks equivalent to jumping out of a plane with a parachute. *Compare* Pet. App. 606a (risk of accidental contraction of HIV when giving intra-oral injection is approximately 1 in 66,667 *with* Pet. App. 596a (risk of fatal accident while skydiving in 1992 is approximately 1 in 100,000).

The terrible but unavoidable conclusion, frankly put, is that federal law in the Eleventh Circuit puts a higher value on the lives of prison inmates than the First Circuit puts on dental workers. Small or low HIV risks to prison inmates are legally significant, but similarly small or even greater risks to dental workers are not.

CONCLUSION

The Court should grant certiorari to bring sense to a senseless conflict among the circuits on what level of risk is legally significant and, unfortunately, whose lives appear to count for more in a direct threat analysis. The Court can accomplish this goal by reiterating "Who is at risk?" is not a proper factor in the direct threat analysis and by remanding for a trial under an appropriate qualitative or quantitative standard of significance similar to the one articulated by the Eleventh Circuit.

At the same time, Dr. Bragdon's support for the Eleventh Circuit's approach does not mean he agrees with all the particular results reached in *Onishea*. Even under a properly cautious approach to direct threat, it is not clear to Dr. Bragdon that HIV-infected prison inmates really pose a direct threat to other inmates in all of the programs listed in *Onishea*, e.g., horticultural classes, clerical classes, floral design classes, college classes, and so forth. To the extent there is no direct threat in some of those instances, the problem is not the standard for significant risk set by the Eleventh Circuit. The problem, instead, appears to be a failure to genuinely apply the standard on an individualized basis both by program and by prison inmate involved. Of course, it may also be that such individualized

assessments are not judicially feasible, or administratively feasible in a prison environment.

The important point is that like the Eleventh Circuit, Dr. Bragdon is not, and has never argued for a "no risk" standard whereby normal classroom situations or other casual contacts with HIV-infected persons might be deemed significant risks. Otherwise stated, while Dr. Bragdon would have no qualms hugging HIV-infected persons in his office, it is a different matter manipulating needles and other sharp instruments in the back of their mouths and putting his face in an aerosol mist of their bloody saliva. For the latter, Dr. Bragdon desired to exercise additional precautions, beyond universal precautions, as 1987 CDC Guidelines said he should. Pet. App. 459a.

Wherefore, Dr. Bragdon respectfully requests that the Court grant his petition for a writ of certiorari and give him an opportunity at trial to show he reasonably assessed the risk as significant based on medical and objective evidence available in September 1994.

Respectfully Submitted,

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